

LETTERS

Diabetes—What's in a Name?

The American Diabetes Association (ADA) new diagnostic criteria for the diagnosing of diabetes, recommending a fasting plasma glucose (FPG) value for people without clinical symptoms, provides a much simpler method to diagnose diabetes than the oral glucose tolerance test (OGTT) required by the World Health Organization (WHO).¹ The ADA suggest that the FPG is simpler, less expensive, more acceptable to patients and more reproducible but will result in fewer people being diagnosed with diabetes. We have examined all glucose tolerance tests performed at Bournemouth between January and July 1997 and reclassified them according to the 'new' ADA recommendations.

Number of OGTT = 219
 Excluded because screened for gestational diabetes = 95
 Total of OGTT analysed = 124
 (70 male; average age 64 years ranging from 46–82 years)

Results

Thus, 4 % would have their status changed from impaired glucose tolerance to 'diabetes' but worryingly, 11 % of patients previously labelled as 'diabetic' would now be re-classified as 'not diabetic' or having impaired fasting glucose (Table 1 below). The concern is that these patients would become part of the problem which the ADA sought to address, namely, several years of hyperglycaemia resulting in complications and 'silent' morbidity upon diagnosis. The HbA_{1c} of all patients newly diagnosed with Type 2 diabetes at Bournemouth was 10.4 ± 3.9 (normal range <6.5 %) but the HbA_{1c} of those

who would now be reclassified as not having diabetes was 6.3 ± 1.1 .

In Bournemouth there is a nurse-led open access system whereby newly diagnosed Type 2 patients are seen within 1 week of diagnosis. Data have been collected on a group of 156 patients who entered this programme in 1994 and have been followed up for 3 years. 16 % of these were diagnosed through OGTT. If these were to be re-classified according to the ADA recommendations, 10 % would not be diagnosed as having diabetes. Fortunately, only one patient out of this 10 % had complications of diabetes detected at diagnosis and this person is also the only one to require medication to control his diabetes.

This is a small local sample but the conclusion based on this evidence suggests that the recommendation of the ADA of using FPG in preference to OGTT would reduce the numbers of individuals with diabetes but would not result in missing the complications of diabetes at least over a 3-year period.

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Reference

1. Harris MI, Eastman RC, Cowie CC, Flegal KM, Eberhardt MS. Comparison of diabetes diagnostic categories in the U.S. Population According to 1997 American Diabetes Association and 1980–1985 World Health Organization Diagnostic Criteria: *Diabetes Care* 1997; **20**: 1859–1862.

Spouse's Worries Concerning Diabetic Partner's Possible Hypoglycaemia

Occurrence of severe hypoglycaemia¹ is common² and can have major negative

consequences, ranging from embarrassment to phobic fear³ to death.⁴ Clinical experience suggests these negative sequelae affect both the patient and their families, including parents,⁵ spouses, and children. There has been only one study that quantified this impact. Gonder-Fredrick *et al.*⁶ studied an American sample volunteering for a long-term clinical trial.⁷ They found spouses of patients with frequent severe hypoglycaemia had more fear of hypoglycaemia, more marital conflict surrounding diabetes management, and more sleep disturbance while worrying about nocturnal hypoglycaemia than spouses whose diabetic partner had not had recent severe hypoglycaemia. The current data comes from another country (Switzerland), from patients who were not participating in a clinical trial.

Participants were emergency room patients presenting for the treatment of severe hypoglycaemia at the University Hospital, Basel. All patients had Type 1 diabetes mellitus, reported a mean of 6.1 episodes of severe hypoglycaemia in their lifetime, and a mean of 2.0 in the past year. Mean duration of diabetes was 17.7 ± 11 years. Spouses were asked to participate in a home interview dealing with 'living with hypoglycaemia'; five refused. There were 38 husbands and 22 wives, average age 43 ± 16 years. During a structured interview, spouses were asked three questions concerning severe hypoglycaemia (Table 1 overleaf).

This culturally different sample and different data collection strategy revealed findings similar to the American study:⁶ the psychosocial impact of severe hypoglycaemia goes beyond the patient experiencing the event. While this survey did not have a comparison group, it did demonstrate that the possibility of a partner having severe hypoglycaemic has multiple implications. When the partner is late, for nearly 1/5 of the subjects the first concern was the possibility of a severe hypoglycaemic episode. Severe hypoglycaemia was a source of concern or 'consternation' for 2/3 of the sample. Finally, for nearly 10 % of the spouses,

Table 1. Changes in diagnostic status from WHO criteria to ADA criteria (mean)

Number	%	FBS (mmol l ⁻¹)	SD	2 h value (mmol l ⁻¹)	SD	WHO definition	ADA definition
57	46	4.8	0.8	6.5	1.5	No diabetes	No diabetes
0.8	14	6.5	0.3	9.4		Impaired glucose tolerance	Impaired fasting glucose
9	7	5.6	0.3	9.8	2.1	Impaired glucose tolerance	No diabetes
5	4	7.8	0.7	9.5	1.2	Impaired glucose tolerance	Diabetes
3	2	5.7	0.2	12.9	0.2	Diabetes	No diabetes
11	9	6.6	0.4	14.1	2.0	Diabetes	Impaired fasting glucose
22	18	9.2	1.6	16.3	3.2	Diabetes	Diabetes